Clinical Audit
SUPPORT CENTRE

ROOT CAUSE ANALYSIS HISTORY

1920s
PIONEER

GO

Japanese inventor, Sakichi Toyoda often viewed as the 'father of RCA' for the work he carried out in the 1920s in relation to the five whys.

1950s - Toyoda's descendants set up Toyota and they adopt his work in relation to Jidoka and the five whys.

1960s/70s/80s - RCA techniques start to evolve and become mainstream in manufacturing and other industries such as General Electric, Federal Aviation Administration, NASA, etc.

1997
KEY MOMENT

The Joint Commission (who accredit over 20,000 healthcare providers in the USA) state members must adopt RCA to review certain patient safety incidents, e.g. unexpected death, wrong site surgery.

2001 - National Patient Safety Agency established in England to help reduce untoward incidents. NPSA quickly advocate RCA to healthcare teams and set up a range of 1/2 and 3 day training courses for NHS teams. By 2007, at least 7,000 NHS staff had been trained in RCA methodology.

2004
NPSA TOOLKIT

The National Patient Safety Agency publish a wide range of materials that collectively form part of a best practice toolkit to help teams conduct best practice in RCA.

2013 - Professor Donald Berwick's report into patient safety in the NHS endorses the continued use of RCA.

Today - The Care Quality Commission routinely ask for evidence of RCA. They use this information to ensure that steps are being taken to learn lessons and improve safety.